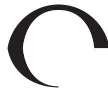

O M N I E Y E S E R V I C E S

Agreement of Responsibility

I understand the professional services are rendered to the patient and the patient is responsible for the charges incurred. I understand I am financially responsible for the charges not covered by my insurance company. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I have received and reviewed the payment policy and agree to the conditions set forth in such policy. I understand I will receive a monthly statement for any balance due by me.

Initial: _______________

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Initial: ________________

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have received a copy of Omni Eye Specialist's P.A. Notice of Privacy Practices.

Initial: ____________

Release of Information/Assignment of Benefits

I authorize the use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of an original. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered.

Name: ________________________________ Date: ____________________

Signature: ________________________

Patient Information

Demographics

NAME (LAST / FIRST / MI)		TODAY'S DATE		
STREET ADDRESS	APT#	SOCIAL SECURITY #		
CITY		E-MAIL ADDRESS		
STATE	ZIP CODE	BIRTH DATE	AGE	SEX ☐ F ☐ M

HOME PHONE	WORK/ MOBILE PHONE	MARITAL STATUS
( )	( )	☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

EMPLOYER NAME/ADDRESS		POSITION/DEPARTMENT
SPOUSE		WORK PHONE/ MOBILE PHONE ( )
EMERGENCY CONTACT	PHONE ( )	SPECIAL NEEDS: ☐ HEARING IMPAIRED ☐ TRANSLATOR ☐ WHEELCHAIR

Referral

PLEASE FILL OUT THIS AREA TO LET US KNOW HOW YOU WERE REFERRED TO OUR OFFICE

NAME OF OPTOMETRIST	PHONE ( )	☐ PATIENT: NAME ______
LOCATION		☐ OTHER PHYSICIAN ______ ☐ INSURANCE DIRECTORY ☐ OMNI WEB SITE ______

STREET ADDRESS	CITY	STATE	ZIP CODE

PRIMARY CARE MEDICAL DOCTOR			PHONE ( )
STREET ADDRESS	CITY	STATE	ZIP CODE

Billing

Guarantor (Person Financially Responsible)

NAME	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Other	
STREET ADDRESS / APT#	PHONE ( )	
CITY	STATE	ZIP CODE

PRIMARY INSURANCE	POLICY HOLDER	POLICY ID#	SS#	INSURED'S DOB
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID#	SS#	INSURED'S B/D

☐ WORKERS COMPENSATION

(over)

OMNI EYE SERVICES

OES-020